COMMONWEALTH of VIRGINIA
Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220
FAX: (804) 367-9740

AGREEMENT TO PAY BENEFITS IN A FATAL CASE

VWC File No. _____ Insurer Claim No. _____
Name of Insurer _____

NOTE: This agreement, when executed, shall be filed promptly by the employer or insurance carrier with the Commission.

Agreement entered into this _____ day of _____, 20__, by and between _____ (Name of Employer) of _____ (Employer's address) and _____ (Name of Principal Dependent) of _____ (Principal Dependent's address) for compensation due the dependents of _____ (Name of Employee), an employee of said Employer who sustained an injury on the _____ day of _____, 20__, as a result of an accident arising out of and in the course of his/her employment and which resulted in death on the _____ day of _____, 20__.

This Agreement is based on the following agreed facts:

Place of Accident _____
Cause of Injury or Illness _____
Nature of Injury or Illness _____
Pre-Injury average weekly wage was $_____

That the following was/were totally or partially (circle one) dependent on the deceased employee prior to the accident:

NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP TO DECEASED

Subject to the approval of the Virginia Workers' Compensation Commission, the Employer agrees to pay and the Principal Dependent agrees to accept compensation for the benefit of the above-named dependent(s), in equal proportions, at the rate of $_____ per week, payable every _____ week(s) for _____ week(s), unless subsequent conditions require a modification, and all costs of necessary medical, surgical and hospital attention and supplies incident to the injury and cost of burial expenses in the sum of $_____.

If dependency was partial, the following statements must be completed:

Total monthly or yearly (circle one) amount necessary to support dependents prior to the accident was $_____.

The deceased contributed the sum of $_____ for the month or year (circle one) prior to the accident for the support of said dependent.

Principal Dependent	Print Name	Phone ( )	Date / /
Insurer or authorized representative (signature of processor)	Print Name	Phone ( )	Date / /
Name and address of Insurer			
Name and address of attorney (if represented)	Fee Approved by		Date / /

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Agreement to Pay Benefits in a Fatal Case
VWC Form No. 35

This form is used in cases that involve a compensable fatality to an injured worker with dependents. The Agreement form provides information relating to the deceased injured worker's weekly wage and compensation rate, as well as the identity of dependent(s) entitled to receive compensation benefits pursuant to the Virginia Workers' Compensation Act. This Agreement, when executed, must to be filed promptly with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220, by the employer, insurer or authorized representative.

Forms: Additional copies of this form are available without cost by writing to the Commission. Address your inquiries to "forms" at the listed Virginia Workers' Compensation Commission address or visit our Website at www.vwc.state.va.us.

For questions or assistance with completing the form, please contact the Claims Examination Department using the Commission's Toll-free number at (1-877) 664-2566.